## Welcome to the Healthy Active Living Quality Improvement Collaborative

- Download LS1 materials here: http://www.contentedits.com/img.asp?id=33730
- There is Wi-Fi in the Bradley Center. Select the CHSGUEST account in their list of available Wi-Fi networks
- Take some time to open your laptop and determine that you can successfully log into RMEDE (you will need to know your username and password) for the Planned Care segment this afternoon. https://hal.rmede.net/
- Identify if you are Red Team or Blue Team for the HAL Encounter Form Breakout Session.
- You will be using PDSA sheets for various segments, take time to locate them in your packets.

## Team Assignments for Breakout Session

| Blue Team | Red Team |
|---|---|
| Athens Limestone Pediatric Clinic | Pediatric Care Center of Northeast AL |
| Charles Henderson Child Health Center | Phenix City Children's |
| COA Adolescent Health Center | Purohit Pediatric Clinic |
| Dothan Pediatric Healthcare Network | UAB Primary Care Clinic |
| Huntsville Pediatric Associates | USA Midtown Pediatrics |
| Mobile Pediatric Clinic | |
| Partners in Pediatrics | |

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Alabama Child Health Improvement Alliance

## Healthy Active Living: An Obesity Prevention and Treatment Quality Improvement collaborative

*August 23, 2014*
*7:30 AM to 3 PM*
*The Bradley Lecture Center*
*Birmingham, AL*

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## Welcome and Introductions

*Cathy Wood, MD, FAAP*
*Alabama Chapter-AAP – Physician Leader*
*August 23, 2014*

## Commercial Interests Disclosure

Cathy Wood, MD, FAAP

- Does not intend to discuss any commercial products or services
- Does not intend to discuss any non-FDA approved uses of products/providers of service
- No significant financial relationship

## Introductions- ACHIA Team

- Cason Benton, MD, FAAP, UAB Department of Pediatrics, ACHIA Director
- Stephenie Wallace, MD, MSPH, UAB Pediatrics, Director of UAB Pediatric Weight Management Clinic
- Bonnie Spear, PhD, RDN, LD, UAB Pediatrics, lead author of 2007 Expert Committee Recommendations for Child and Adolescent Overweight and Obesity
- Daniel L. Preud'Homme, MD, CNS, Pediatric Gastroenterology Hepatology & Nutrition, Director-Pediatric Healthy Life Center, Diplomate-American Board of Clinical Lipidology, Professor, Pediatrics – The University of South Alabama

## Introductions- State Faculty

- Cathy Wood, MD, FAAP, Alabama Chapter-AAP HAL Physician Leader
- Linda Champion, MPA, Alabama Chapter- AAP and ACHIA Project Manager
- James Muisyo, MSC, Center for Strategic Health Innovation - University of South Alabama
- Daphne Butera, BSN, RN, Adolescent Health Center, Clinical Coordinator, COA

## Participating Practices

Athens Limestone Pediatric Clinic
Charles Henderson Child Health Center
COA Adolescent Health Center
Dothan Pediatric Healthcare Network
Huntsville Pediatric Associates
Mobile Pediatric Clinic
Partners in Pediatrics
Pediatric Care Center of Northeast AL
Phenix City Children's
Purohit Pediatric Clinic
UAB Primary Care Clinic
USA Midtown Pediatrics

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## ACHIA and the Healthy Active Living Vision for the Collaborative

*Cason Benton, MD, FAAP*
*UAB Department of Pediatrics*
*ACHIA Director*
*August 23, 2014*

## Commercial Interests Disclosure

E. Cason Benton, MD, FAAP

- Does not intend to discuss commercial products or services.
- Does not intend to discuss non-FDA approved uses of products/providers of services.
- Does not have a relevant financial arrangement or affiliation with any commercial interest related to this activity.

## What is ACHIA? Our Collaborative Partners

American Academy of Pediatrics
Alabama Chapter
UAB MEDICINE PEDIATRICS
Children's of Alabama
BlueCrossBlueShield Of Alabama
ALLKIDS

## Cason's Road to QI

## Goals for the Shared Vision

- National perspective
- Vision of the ACHIA and the Alabama Chapter-AAP QI Committee
- Understand the "gap" in obesity treatment and prevention care
- Understand why this work is important
- Become familiar with the goals for this project

## Why Obesity Prevention and Treatment QI?

- **CHILDHOOD OBESITY** has nearly tripled in Alabama over the last 30 years
- The percentage of children ages 10-17 who are obese is 36%
- Low income children ages 2-5 years 29% are overweight or obese
- Alabama will spend 5.5 billion dollars on health care attributable to obesity annually by 2018

## Childhood Obesity: Scope of the Problem

- **Epidemic** – Widespread in population (adults and children)
- **Progressive** – Childhood obesity becomes adult obesity
- **Alters Development** – Physically, emotionally, psychosocially
- **Chronic disease** – Lifelong morbidity accelerates "adult" disease into childhood
- **Increases morbidity/mortality** – First generation to have shorter lifespan than parents

## Complex but conquerable


## Why?

- Maintenance of Certification
- Changes in payment model
- Demand for accountability and outcomes
- Patient and family desire for consistent, quality care

**AND**

## GAPS in Care

- Obesity is a common chronic condition
- Treatment consistent with guidelines improves health status

## Improvement is Bigger than One Person

- Team-based approach to care
- Create systems instead of trying to sustain increased effort
- Start small
- Trial and LEARNING *not* Trial and ERROR

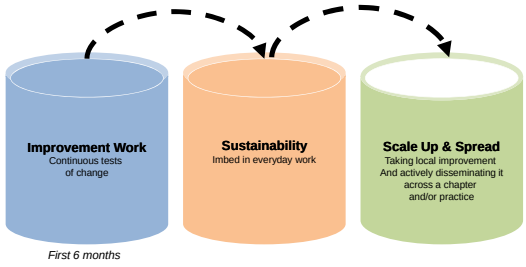
## Three-prong approach

- Quality Improvement Faculty and Coach working with a practice based teams
- Learning Collaborative
  - QI content
  - Clinical content
  - Data transparency
- Database functionality
  - Report measures monthly to practice teams

## QI science

- The science behind QI can be overwhelming
- Key to remember that QI is for the provider and the practice- this is not research on patients
- QI is all about taking evidence based medicine beyond the CME lecture and into actual practice

## Improvement Work




## Global Aim

*We will build a sustainable quality improvement infrastructure in our practice to achieve measurable improvements in the delivery of obesity prevention and treatment*

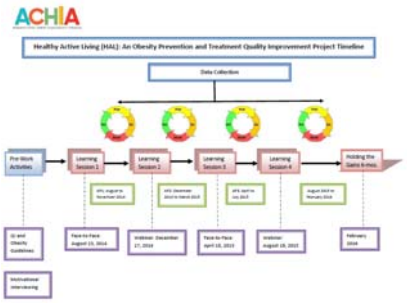
## Specific Aim

*From Summer 2014 to Fall 2015 we will achieve measurable improvements in the delivery of obesity prevention and treatment by implementing Expert Committee Recommendations on Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity -2007*

## How will we measure success?

- Use of the Healthy Active Living (HAL) Encounter Form content
- Initiating conversations with parents using communication techniques supportive of change behavior
- Capturing Process Measures
- Changing Process to meet our goals

## HAL-QI Project Timeline



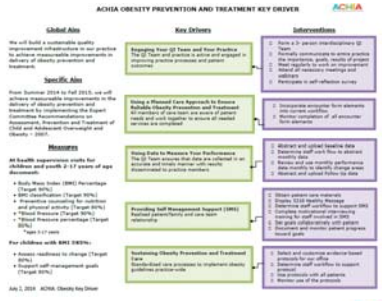
## Healthy Active Living Encounter Form

## Measures

- At health supervision visits 2-17 years of age:
  - Body Mass Index (BMI) – target 90%
  - BMI Classification – target 90%
  - Blood Pressure* - target 90%
  - Blood Pressure percentage* - target 80%
  - For children and youth with BMI ≥ 85%:
    - Assess readiness to change – target 80%
    - Support self-management goals – target 80%

*Blood Pressure for 3 years of age or older

## Key Driver



## Change Concepts

➢ **Engagement of Core QI Team**
*The QI Team and practice is active and engaged in improving practice processes and patient outcomes*

➢ **Using a Planned Care Approach to Ensure Reliable Obesity Prevention and Treatment**
*All members of care team are aware of patient needs and work together to ensure all needed services are completed*

## Change Concepts

- **Using Data to Measure your Performance**
  *The QI Team ensures that data are collected in an accurate and timely manner with results disseminated to practice members*
- **Providing Self Management Support**
  *Realized patient/family and care team relationship*
- **Sustaining Obesity Prevention and Treatment**
  *Standardized care processes to implement obesity guidelines practice-wide*

## Simplified Care Model


Templates for planned care
- (e.g., structured encounter form)

Protocols to standardize care
- Standard Protocols
- Nursing Standing Orders
- Defined Care team roles

Self-management support strategies

## AIMS for PRACTICES at Health Supervision Visits by September 2015

- 90% of practices will documented BMI
- 80% of patients will have documented Counseling for Nutrition
- 80% of patients will have documented Counseling for Physical Activity
- 90% of patients will have documented Weight Classification
- 90% of practices will have documented Blood Pressure Screening
- 80% of practices will have documented Blood Pressure Percentile

**For Patients with BMI ≥ 85%**
- 80% of patients will have Readiness to Change assessed
- 80% of patients will have documented Self-Management Support goal

## MOC Part 4 Criteria for Physicians

- Provide direct or consultative patient care in the improvement project.
- Complete one or more tests of change to improve patient care.
- Complete data collection at the time of the visit using the Healthy Active Living (HAL) Encounter Form for decision support and load the data into the Healthy Active Living (HAL) Database by the monthly deadline.
- Enter into the HAL Database all data elements for the baseline data (15 charts) and a minimum of 10 patient visits per month for at least 9 of the 12 months.
- Review encounter-level data and practice level performance.
- Attend four or more project meetings or calls. For QI Lead Physicians seeking MOC this includes attendance at the Healthy Active Learning Sessions, webinars, and the monthly conference calls. For a Participating Physicians* in the practice seeking MOC this includes a combination of the following to meet the requirement of four: monthly practice calls, or attendance at practice huddles/practice team meetings lead by your practice QI Lead Physician. *QI Physician Leads will be required to lead practice meetings and attest that providers seeking MOC have met this requirement.
- Stay active in the project for a minimum of 12 months.

## MOC Part 4 Criteria for the Practice

- Presence of a documented process map that details reliable data collection at the time of the visit
- Established Core QI Team (physician, nurse or MA, and practice manager)
- Members of Core QI Team attend learning sessions
- Core QI Team representation on monthly calls
- Core QI Team has a minimum of four practice meetings with all providers and staff in the practice

## Obesity Prevention and Treatment Care a Year From Now

- Healthier Patients
- Easier use of obesity guidelines by physicians and staff
- Better understanding of obesity prevention and treatment for patients and families
- Better systems so your office members can function as an efficient team
- Knowing your patients and being ready for their visits
- The best care for every patient, every time

## Shared Vision

*Questions*

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**Starting with the End in Mind: Creating a Reliable System of Obesity Prevention and Treatment**

Children's of Alabama

UAB MEDICINE PEDIATRICS

*Cason Benton, MD, FAAP*
*UAB Department of Pediatrics*
*ACHIA Director*
*August 23, 2014*

## Commercial Interests Disclosure

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"Every system is perfectly designed to get the results it gets"

Paul Batalden

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## Childhood Obesity

- **Epidemic** – Widespread in population (adults and children)
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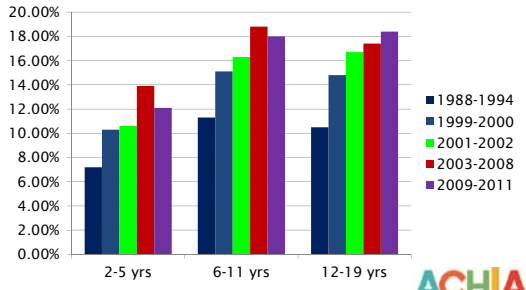
## Trends in Childhood Obesity, NHANES 1988-2011

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Ogden, 2008, Ogden,2012

## Why doctors do not currently identify and counsel patients about weight

- Do not recognize obesity
- Not trained to prevent/treat obesity
  - how to effectively counsel (MI)
  - what to say (5210)
- Obesity counseling not reimbursed
- Overwhelmed
- History of lack of success

## Next Steps: Accelerating Progress in Obesity Prevention

- Institute of Medicine May 2012
  - Promote Daily Physical Activity
  - Healthy Food Everywhere
  - Market a Healthy Life
  - **Activate** Employers and **Health Care Providers**
  - Strengthen School as Heart of Health

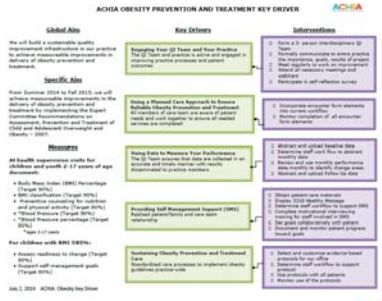
## What's Your Current System of Assessing children for obesity prevention and treatment at the health supervision visit?

- Has your practice implemented the Expert Committee Recommendations ?
- Does your practice have a standard encounter form for identifying and documenting childhood obesity prevention and treatment ?
- Do you routinely assess patients for BMI, BMI Classification, Blood Pressure, Blood Pressure %,, readiness for change and provide SMS?
- Do you pre-plan follow-up visits with patients identified as overweight or obesse ?

## Quality Improvement (QI) Approach

- QI Faculty and coach work with practice-based teams
- Learning Collaboratives
  - Clinical content
  - QI content (PDSA, Key Drivers)
  - Data transparency
- Data and assessment functionality
  - Report measures monthly to practice teams

## Key Drivers of Change




## Engaging Your QI Team and Practice

***The QI Team and practice is active and engaged in improving practice processes and patient outcomes***

- Form a 3- person interdisciplinary QI Team
- Formally communicate to entire practice the importance, goals, results of project
- Meet regularly to work on improvement
- Attend all necessary meetings and webinars
- Participate in self-reflection survey

## Practice Engagement and Why it is Important

- Change is hard for everyone and it is important to have a plan so everything goes smoothly as possible
- Changes will first be started on a small scale, but will need to be spread practice wide to have an impact on all asthma patients
- By engaging your practice early on in this program, you will remove barriers to spreading this work throughout the year

## Using a Planned Care Approach to Ensure Reliable Obesity Prevention and Treatment

***All members of care team are aware of patient needs and work together to ensure all needed services are completed***

- Incorporate encounter form elements into current workflow
- Monitor completion of all encounter form elements

## Using Data to Measure Your Performance

***The QI Team ensures that data are collected in an accurate and timely manner with results disseminated to practice members***

- Abstract and upload baseline data
- Determine staff work flow to abstract monthly data
- Review and use monthly performance data monthly to identify change areas
- Abstract and upload Follow Up data

## Providing Self-Management Support

***Realized patient/family and care team relationship***

- Obtain patient care materials
- Display 5210 Healthy Message
- Determine staff workflow to support SMS
- Complete motivational interviewing training for staff involved in SMS
- Set goals collaboratively with patient
- Document and monitor patient progress toward goals

## Sustaining Obesity Prevention and Treatment

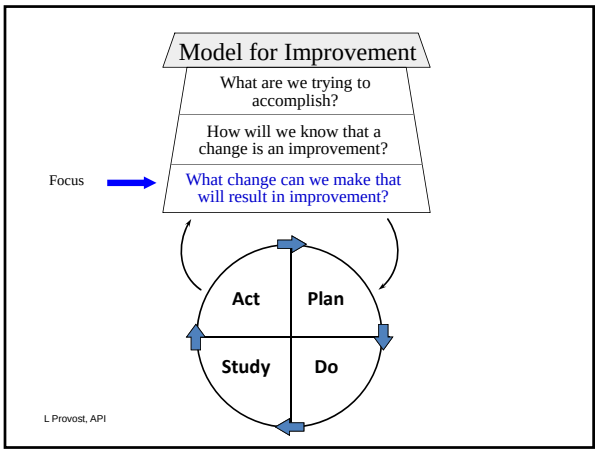
***Standardized care processes to implement obesity guidelines practice-wide***

- Select and customize evidence-based protocols for our office
- Determine staff workflow to support protocol
- Use protocols with all patients
- Monitor use of the protocols

## How to produce continuous, enduring improvements in care for a population?

- Appreciation for care as a system
- Flexible improvement model
- Sequential building of knowledge
  - Testing changes on a small scale
  - Spread of improvements to similar sites
- Efficient and effective use of data
  - Usefulness not perfection

Tom Nolan, PhD




## What *change* can we make that will lead to improvement?

***Change Concept:*** **a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement.**

L Provost, API

## Moving from Concepts to Ideas

**Conceptual, Vague Strategic**

↓

↓

↓

**Specific Actionable Ideas**

**Decision support**

↓

**Use a template**

↓

**Use the HAL-QI Encounter form for each health supervision visit for ages 2 - 17**

↓

**Incorporate HAL-QI form into flow and try it on two patients next Monday**

## HAL-QI Hi-Leverage Changes

- Use Healthy Active Living Clinical Care Encounter form (template) for Planned Care
- Implement a method to identify and manage children with obesity at the health supervision visit
- Use Protocols
- Adopt Self-management Support Strategies

## Chronic Care Model/CQN High Leverage Changes

| | Database | Template | Protocols | Self Management Support |
|---|---|---|---|---|
| Delivery System Design | * Determine Staff workflow to support HAL-QI Database support | * Determine staff workflow to support use of the HAL-QI Encounter Form<br>* Monitor use of the encounter form<br>* Determine staff workflow to support protocols, including standing orders<br>* Monitor use of the protocols | | * Determine staff workflow to support SMS<br>* Provide training to staff in SMS techniques<br>* Document & monitor patient progress toward goals |
| Decision Support | * Use the database to manage patient care and support population management | * Select encounter form or create a workflow sheet<br>* Use encounter form with all patients at the health supervision visit | * Select and customize evidence-based protocols for the office<br>* Use protocols with all patients at the health supervision visit<br>* Assess and document readiness to change<br>* Establish visit frequency protocol | |
| Clinical Information Systems | * Select and install a registry tool<br>*Populate registry with patient data<br>* Routinely maintain registry data | * Ensure registry is updated each time the encounter form template is used | | |
| Self Management Support | | | | * Obtain patient education materials<br>* Set patient goals collaboratively<br>*Use 5210 handouts and resources |
| Community | | | | * Link with community resources (schools, service organizations, after-school facilities and programs |

## Evidence that System Change Works

(Cochrane Review; JAMA 2002; Diabetes 2001)

- 40 studies (85% RCTs) (mostly in primary care)
- Four categories of interventions:
  - Decision support
  - Delivery system design
  - Changes to information systems
  - Self-management
- 19/20 that included self-management had a positive effect
- The five studies that included all 4 categories had a positive effect

## Conclusions

- No "magic bullet" – no single intervention made a major difference
- Self-management is necessary, but not sufficient
- More intervention categories addressed, greater impact on patient outcomes
- Comprehensive system changes are needed to improve outcomes

## Putting It All Together

- Create a strong practice team
- Clarify what you are trying to accomplish
- Try high-leverage changes
- Measure progress
- Refine and customize changes
- Share and integrate learning

## Questions

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**Overview of the Clinical Guidelines: Obesity Prevention and Treatment Review**

*Stephenie Wallace, MD, MSPH*
*Medical Director, Children's Center for Weight Management*
*Assistant Professor, UAB Pediatrics – Adolescent Medicine*
*August 23, 2014*

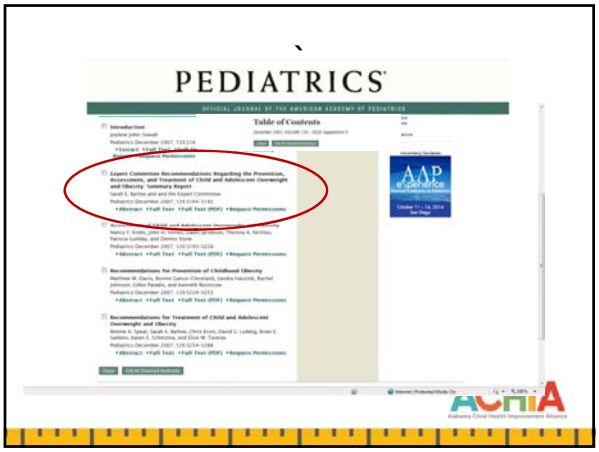
## Commercial Interests Disclosure

Stephenie Wallace, MD, MSPH:

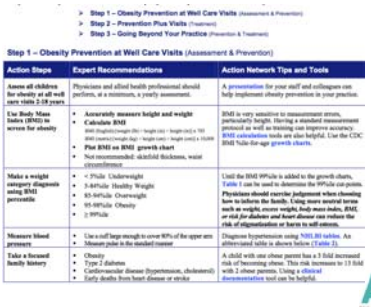
- Does not intend to discuss any commercial products or services
- Does not intend to discuss any non-FDA approved uses of products/providers of service
- No significant financial relationship

## Objectives

- **For participants to be familiar with the Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report**




## NICHQ Childhood Obesity Action Network Summary




## Prevention

- All children are considered "at risk for obesity."
- Message at **well visits**
  - Simple
  - Consistent
  - Cumulative prevention
- "Gateway message" to nutrition, activity, and high risk behavior

## Obesity Prevention at Well Child Care Visits

- Assess all children for obesity at well child care visits 2-18 years of age
  - Minimum: yearly assessment
- Will discuss assessment in the order of a clinic visit

## Well Child Visit

- Triage – Vital Signs
- Patient/Family Interview (HPI)
- Update of Medical, Family, Social History
- Physical Exam
- Medical Assessment
- Patient/Family Discussions

## VITAL SIGNS

## Use BMI to screen

- Body Mass Index (BMI) is a screening measure, determines further evaluation
- BMI based on age and gender and is a population based reference

Goals:

- Accurately measure height and weight
- Calculate BMI
- Plot BMI on growth chart

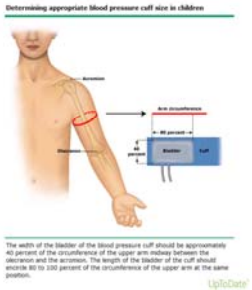
## Make a weight status diagnosis using BMI percentile

- <5% Underweight
- 5-84% Healthy weight
- 85-94% Overweight
- > or = 95% Obese

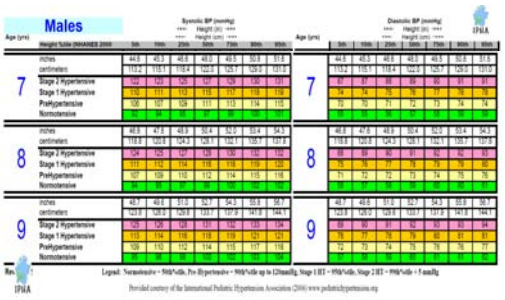
## Blood Pressure


## BP Measurement

- Cuff Size
  - Neonatal, infant, child, small adult, adult, thigh
- Busy, noisy clinic
  - 3-5minutes of rest before taking measurement
  - Not Crying
  - Take 2-3 minutes to rest before measurements




## Classify Blood Pressure




## PATIENT INTERVIEW AND EXAM

## Review of Systems

**Obesity Assessment: Findings on Review of Systems and Possible Etiologies**

| Symptom | Possible Etiologies |
|---|---|
| Anxiety, school avoidance, social isolation | Depression |
| Severe recurrent headaches | Pseudotumor cerebri |
| Shortness of breath, exercise intolerance | Asthma, lack of physical conditioning |
| Snoring, apnea, daytime sleepiness | Obstructive sleep apnea, obesity hypoventilation syndrome |
| Sleepiness or wakefulness | Depression |
| Abdominal pain | Gastroesophageal reflux disease, constipation, gall bladder disease, nonalcoholic fatty liver disease* |
| Hip pain, knee pain, walking pain | Slipped capital femoral epiphysis, Blount disease, musculoskeletal stress from weight (may be barrier to physical activity) |
| Foot pain | Musculoskeletal stress from weight (may be barrier to physical activity) |
| Irregular menses (<9 per year) | Polycystic ovary syndrome; may be normal if recent menarche |
| Primary amenorrhea | Polycystic ovary syndrome, Prader-Willi syndrome |
| Polyuria, polydipsia | Type 2 diabetes mellitus* |
| Unexpected weight loss | Type 2 diabetes mellitus* |
| Nocturnal enuresis | Obstructive sleep apnea |
| Tobacco use | Increased cardiovascular risk; may be as form of weight control |

*These conditions are often asymptomatic.

American Academy of Pediatrics. Pediatric Obesity Clinical Decision Support Chart. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

## Focused Family History

- Obesity
- Type 2 Diabetes
- Cardiovascular Disease (HTN, cholesterol)
- Early death from heart disease or stroke

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## Focused Social History

- Focused Family History
- Social History
  - Food insecurity
  - Multiple caregivers
  - Lack of safe outdoor environment

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## Physical Examination

**Obesity Assessment: Physical Examination Findings and Possible Etiologies**

| System | Findings | Possible Explanations |
|---|---|---|
| Anthropometry | • High body mass index percentile<br>• Short stature | • Overweight or obesity<br>• Underlying endocrine or genetic condition |
| Vital signs | • Elevated blood pressure | • Hypertension if systolic or diastolic blood pressure >95th percentile for age, gender, and height on ≥3 occasions |
| Skin | • Acanthosis nigricans<br>• Hirsutism, acne<br>• Irritation, inflammation<br>• Violaceous striae | • Common in obese children, especially when skin is dark; increased risk of insulin resistance<br>• Polycystic ovary syndrome<br>• Consequence of severe obesity<br>• Cushing syndrome |
| Eyes | • Papilledema, cranial nerve VI paralysis | • Pseudotumor cerebri |
| Throat | • Tonsillar hypertrophy | • Obstructive sleep apnea |
| Neck | • Goiter | • Hypothyroidism |
| Chest | • Wheezing | • Asthma (may explain or contribute to exercise intolerance) |
| Abdomen | • Tenderness<br>• Hepatomegaly | • Gastroesophageal reflux disorder, gall bladder disease, nonalcoholic fatty liver disease (NAFLD)*<br>• NAFLD* |
| Reproductive | • Tanner stage<br>• Apparent micropenis<br>• Undescended testis/micropenis | • Premature puberty age <7 years in white girls, age <6 years in black girls, and age <9 years in boys<br>• May be normal penis that is buried in fat<br>• Prader-Willi syndrome |
| Extremities | • Abnormal gait, limited hip range of motion<br>• Bowing of tibia<br>• Small hands and feet, polydactyly | • Slipped capital femoral epiphysis<br>• Blount disease<br>• Prader-Willi syndrome, Bardet-Biedl syndrome |

*These conditions are usually without signs.

American Academy of Pediatrics. Pediatric Obesity Clinical Decision Support Chart. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

## MEDICAL ASSESSMENT

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## Medical Screening by BMI Category

| BMI Percentile | Medication Use | Review of Symptoms | Family History (1st and 2nd degree relatives) | Physical Examination | Laboratory Tests |
|---|---|---|---|---|---|
| 5th–84th (healthy weight) | Medications that may affect weight gain (eg, neuropsychiatric) | | Obesity, type 2 diabetes, hypertension, lipid, heart disease | BP (correct cuff) | |
| 85th–94th (overweight) | Medications that may affect weight gain (eg, neuropsychiatric) | Snoring/sleep; abdominal pain; menstrual irregularities; hip, knee, or leg pain; polyuria; thirst; depression | Obesity, type 2 diabetes, hypertension, lipid, heart disease | BP (correct cuff), acanthosis nigricans, tonsils, goiter, tender abdomen, liver, bowing of legs, limited hip range of motion, optic discs if headaches, acne and hirsutism | • Fasting lipid profile<br>• Fasting glucose, ALT, AST every 2 years |
| 95th–99th (obese) | Medications that may affect weight gain (eg, neuropsychiatric) | Snoring/sleep; abdominal pain, menstrual irregularities; hip, knee, or leg pain; urination; thirst; depression | Obesity, type 2 diabetes, hypertension, lipid, heart disease | BP (correct cuff), acanthosis nigricans, tonsils, goiter, tender abdomen, liver, bowing of legs, limited hip range of motion, optic discs if headaches, acne and hirsutism | • Fasting lipid profile<br>• Fasting glucose, ALT, AST every 2 years |
| >99th | Medications that may affect weight gain (eg, neuropsychiatric) | Snoring/sleep; abdominal pain, menstrual irregularities; hip, knee, or leg pain; urination; thirst; depression | Obesity, type 2 diabetes, hypertension, lipid, heart disease | BP (correct cuff), acanthosis nigricans, tonsils, goiter, tender abdomen, liver, bowing of legs, limp, limited hip range of motion; optic discs if headaches; acne and hirsutism; skin inflammation | • Fasting lipid profile<br>• Fasting glucose, ALT, AST every 2 years |

Abbreviations: BMI, body mass index; BP, blood pressure; ALT, alanine transaminase; AST, aspartate transaminase; BUN, blood urea nitrogen.
*BMI is a screening measure. The higher the BMI, the more likely it is to be correlated with excess fat.
Risk factors include family history of obesity-related diseases, including hypertension, early cardiovascular deaths, and strokes; elevated blood pressure in the patient; hyperlipidemia, and tobacco use.

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American Academy of Pediatrics. Pediatric Obesity Clinical Decision Support Chart. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

## PATIENT DISCUSSIONS

## Partnership with Families

- Families have a critical role in influencing a child's health.
- Effective interaction with families is the cornerstone of lifestyle change.

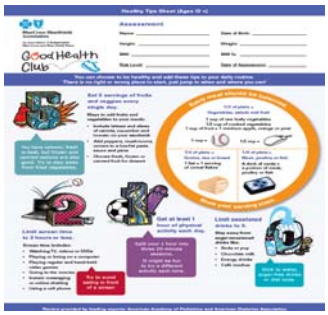
## Communication

- Positive discussion of what healthy lifestyle changes families can make (evidence base)
- Allow for personal family choices.
- Have families set specific achievable goals and follow up with these on revisits.
- Be aware of cultural norms, significance of meals and eating for family/community, beliefs about special foods, and feelings about body size.
- Motivational interviewing

## BMI 5%-84%

- Diet and physical activity :
  - **5** or more servings of fruits and vegetables per day
  - **2** or fewer hours of screen time per day, and no television in the room where the child sleeps
  - **1** hour or more of daily physical activity
  - **No** sugar-sweetened beverages

## 5210 Handout




## Develop an office-based approach for children with BMI ≥85%

- Treatment begins Stage 1 Prevention Plus
  - Targeted ROS, Family and Social History, Physical Exam, and Labs
  - Assessing Readiness to Change
  - Supporting patient and family to select goals

## Patient-Selected Behavioral Goals

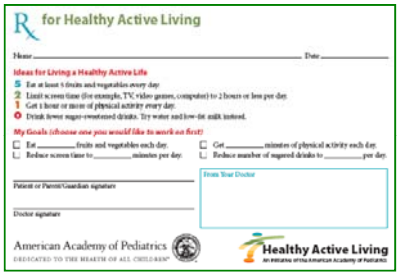
- Assess readiness to change
- Use motivational interviewing for ambivalent families and to improve the success of behavior goals.

## Recommendations with Consistent Evidence

- Multiple studies show consistent association between recommended behavior and either obesity risk or energy balance.
  - Limit consumption of sugar sweetened beverages.
  - Limit TV (0 hours <2 years, <2 hours >2 years old).
  - Remove TV from primary sleeping area.
  - Eat breakfast daily.
  - Limit eating out.
  - Encourage family meals.
  - Limit portion size.

## Recommendations with Mixed Evidence

- Some studies demonstrated evidence for weight or energy balance benefit but others did not or the studies were too few or too small.
  - 5 or more fruits and vegetable servings/day (9 age appropriate servings recommended)
  - e.g. My Plate




## Weight Goals

- Weight goals vary by age and BMI percentiles
- Weight maintenance or a decrease in BMI velocity

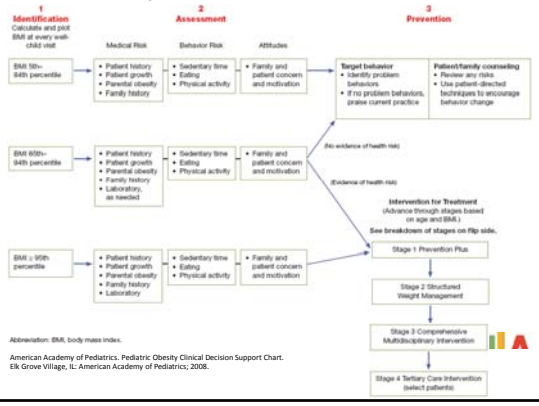
## Weight Loss Targets

| Age, y | BMI 85th-94th Percentile No Risks | BMI 85th-94th Percentile With Risks | BMI 95-98th Percentile | BMI ≥99th Percentile |
|---|---|---|---|---|
| 2–5 | Maintain weight velocity | Decrease weight velocity or weight maintenance | Weight maintenance | Gradual weight loss of up to 1 lb/mo if BMI is very high (>21 or 22 kg/m²) |
| 6–11 | Maintain weight velocity | Decrease weight velocity or weight maintenance | Weight maintenance or gradual loss (1 lb/mo) | Weight loss not to exceed an average of 2 lb/wk* |
| 12–18 | Maintain weight velocity. After linear growth is complete, maintain weight. | Decrease weight velocity or weight maintenance | Weight loss not to exceed an average of 2 lb/wk* | Weight loss not to exceed an average of 2 lb/wk* |

Abbreviation: BMI, body mass index.
*If greater loss is noted, monitor for causes of excessive weight loss.

American Academy of Pediatrics. Pediatric Obesity Clinical Decision Support Chart. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

**Universal Assessment of Obesity Risk: Steps to Prevention and Treatment**




## Develop a Reimbursement Strategy for Prevention Plus Visits

## Future Learning Sessions

- Advocate for fresh fruit and vegetables and safe physical activity in your community and schools
- Identify and promote community services which encourage healthy eating and physical activity
- Identify and develop more intense weight management interventions for your families who do not respond to Prevention Plus

## Summary

- Assess patients' BMI and deliver counseling for healthy nutrition and physical activity at every health supervision visit
- Care for patients with BMI 85% and greater

## Break

- There is Wi-Fi at the Bradley Center. Select the **CHSGUEST** account in their list of available Wi-Fi networks.
- Take some time to open your laptop and determine that you can successfully log into RMEDE (with your username and password) for the Data Abstraction segment this afternoon. If you need assistance locate Linda Champion. https://hal.rmede.net/

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**Introduction to the Healthy Active Living Clinical Care Encounter Form for Obesity Visit Documentation**

Children's of Alabama

UAB MEDICINE PEDIATRICS

*Stephenie Wallace, MD, MSPH*
*Daphne W. Butera BSN, RN*
*Cason Benton, MD, FAAP*
*Bonnie Spear, PhD, RDN, LD*
*August 23, 2014*

## Commercial Interests Disclosure

Benton, Spear, Wallace, Butera:

- Does not intend to discuss any commercial products or services
- Does not intend to discuss any non-FDA approved uses of products/providers of service
- No significant financial relationship

## Team Assignments

Check the color of the dot on your name tag and move to the appropriate tables

- Blue Team – start at Station 1 where you will split into two groups (15 minutes each). At the end of the time and then transition to Station 2.
- Red Team – start at Station 2 and then transition to Station 1.

## Team Assignments for Breakout Session

| Blue Team – Station 1 | Red Team – Station 2 |
|---|---|
| Athens Limestone Pediatric Clinic | Pediatric Care Center of Northeast AL |
| Charles Henderson Child Health Center | Phenix City Children's |
| COA Adolescent Health Center | Purohit Pediatric Clinic |
| Dothan Pediatric Healthcare Network | UAB Primary Care Clinic |
| Huntsville Pediatric Associates | USA Midtown Pediatrics |
| Mobile Pediatric Clinic | |
| Partners in Pediatrics | |

## Using the Clinical Care Encounter Form for Obesity Screening and Prevention

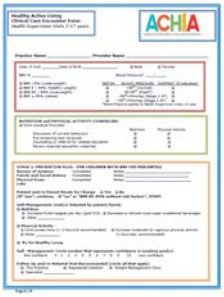
Station 1 (two 15 minute segments):

- Accurate Height and Weight Measurement
- BMI Calculation and Classification
- Blood Pressure Measurement and Percentage

Station 2:

- Delivery of State 1 Prevention Plus for Children with BMI ≥85%
- Review of Systems, Family and Social History
- Targeted Medical Exam and Labs
- Assessing Readiness to Change
- Self-Management Goals
- Assessing Confidence,
- Follow up

## HAL Clinical Care Encounter Form



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## Model of Improvement and PDSA Cycles Team Meeting 1

Children's of Alabama

UAB MEDICINE PEDIATRICS

Cason Benton, MD, FAAP

August 23, 2014

## Commercial Interests Disclosure

E. Cason Benton, MD, FAAP:

- Does not intend to discuss any commercial products or services
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- No significant financial relationship

## Team-Building

- High functioning team
  - Physician champion
  - Autonomous coordinator
  - Engaged team members
  - Good communication
  - Patient care planning meetings

## Effective Meeting Skills


## Meeting Skills

- Ground Rules
- Meeting Roles
- Meeting Process
- Agendas
- Meeting Tools

## Ground Rules

- Practice not interrupting each other
- Work to include other's ideas
- Do unto others as you wish them to do to you
- Try not to repeat the same points-even if you didn't get the emphasis you hoped for the first time you said it
- Practice not defending previously held viewpoints-by suspending them for a while, you might learn something new
- Try not to be too nice at the expense of rigor-help the group progress in it's thinking
- Practice forgiveness for new ideas and ways of learning that don't seem to work as well as they might eventually
- Laugh a little

## Meeting Roles

## Meeting Roles


## Meeting Roles


## Meeting Roles


## 7-Step Meeting Process/Agenda

1. Clarify aims: what we will get done
2. Review roles: leader, recorder, timekeeper, facilitator
3. Review agenda and determine time for each item
4. Work through agenda items
5. Review meeting record: review written record (flipchart, computer, whiteboard) make changes/additions, decide what to keep for meeting record
6. Plan next actions & next agenda: who will do what off line & aims for next meeting
7. Evaluate the meeting: went well, could improve

## Time for Action

- Modify Your Flowchart of Obesity Prevention and Treatment from Current State to Highly Reliable System of Care

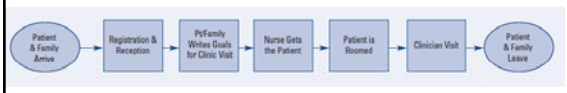
## The Purpose of Flowcharts

Creates a picture of the sequence of steps in a process

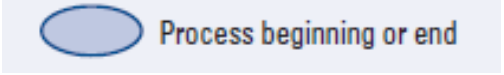
## The Benefits of Flowcharts

- Engages all members of the practice
- Replaces pages of written word with a picture
- Illustrates waste, delays, missteps and duplication in the process being studied
- Builds consensus within the practice
- Corrects misunderstandings about a process
- Builds common understanding of the process

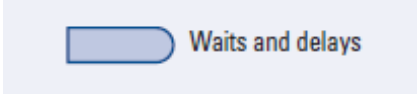
## Simple Flowchart Example

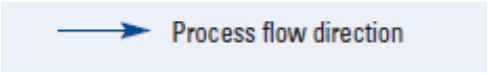


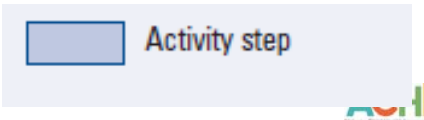

## Shapes Used in Flowcharts

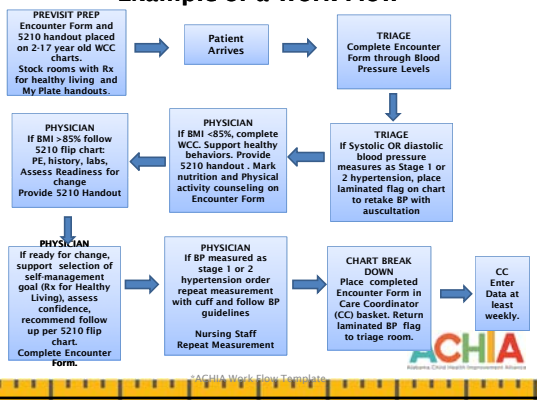

## Shapes Used in Flowcharts




## Example of a Work Flow




*ACHIA Work Flow Template

## Tips for Useful Flow Charts

**Do's**

- ❑ Draft the current process before the ideal process
- ❑ Ask for input of all members of the practice, including patients
- ❑ Observe the process directly or ask a patient to give their perspective
- ❑ Draft the flow chart with post-it notes with all members involved
- ❑ Place the draft in a public place before finalizing

**Don'ts**

- ❑ Have one person or discipline complete the chart
- ❑ Use a pre-determined template

## Time for Action: Modify Your Flowchart

1. Clarify aims: Modify Your Flowchart
2. Assign roles using cards: leader, recorder, timekeeper, facilitator

## Time for Action: Modify Your Flowchart

3. Review agenda and determine time for each item
   - Review current flowchart – 2 minutes
   - Determine changes to create highly reliable flowchart – 10 minutes
   - Finalize flow chart – 2 minutes
   - Review record – 2minutes
   - Determine next steps – 2 minutes
   - Evaluate the meeting - 2 minutes

## Time for Action: Modify Your Flowchart

4. Work through agenda items
5. Review written meeting record: make changes/additions, decide what to keep for meeting record
6. Plan next actions & next agenda: who will do what off line & aims for next meeting

## Time for Action: Modify Your Flowchart

7. Evaluate the meeting: went well, could improve
   - Every member
   - scale of 1-10
   - Clarify rating

## Benefits of Effective Meetings

- Gets the job done
- Engages everyone
- Improved communication
- Allows ownership
- Increases efficiency

## Quick Review: The Benefits of Flowcharts

- Engages all members of the practice
- Replaces pages of written word with a picture
- Illustrates waste, delays, missteps and duplication in the process being studied
- Builds consensus within the practice
- Corrects misunderstandings about a process
- Builds common understanding of the process

## Team Time Assignment #1

**20 minutes**

- Incorporate the HAL Clinical Care Encounter Form into your daily workflow for a few patients scheduled for a Health Supervision Visit over the next 2 weeks.
- Assign team members roles (facilitator, note taker, time keeper) and work through your first workflow

## Team Time Report-Out

**10 minutes**

Report out: On a scale of 1 – 10 how effective was your meeting?

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## Using the HAL Encounter Form for Data Abstraction

*James Muisyo, MSC,, Assistant Medical Director – Center for Strategic Health Innovation*
*Cason Benton, MD, FAAP*
*August 23, 2014*

Children's of Alabama
UAB MEDICINE PEDIATRICS

## Commercial Interests Disclosure

Benton, Muisyo:

- Does not intend to discuss any commercial products or services
- Does not intend to discuss any non-FDA approved uses of products/providers of service
- No significant financial relationship

## Using the HAL Database: Practice Management

**Login https://hal.rmede.net**
Go to the RMEDE website and enter you assigned username and password to login.

**Practice Management**
- Create Practice Sites
- Add Physicians to the Practice or Site
- Add an Approved User to Practice

**HAL Encounters**
- Adding Encounters via Website
- Uploading Encounter in a Spreadsheet
- View Encounters List

## HAL Database Abstraction Form

## Chart Selection for Data Abstraction

**Chart Inclusions**
Children presenting for health supervision visit ages 2-17 years of age.

**Chart Exclusions**
1. Children who cannot stand for height measurement.
2. Children who have hardware that cannot be removed and would result in an inaccurate weight (such as a cast)
3. Youth who are pregnant.

**Permissible Data**
1. Only abstract data documented for the visit.
2. Do not enter data that may have been delivered but was not documented.
3. Do not enter data that can be surmised after the visit; such as BMI percentage or blood pressure percentage, but was not documented at the visit.

## Chart Selection for Data Abstraction

**Chart Selection: Baseline Charts**
Baseline data rationale: for the practice to understand current care delivered for obesity prevention and treatment.
- Time frame: February 1-July 31, 2014
- 15 charts per provider
- Complete data entry by September 19, 2014

**Chart Selection: Monthly Action Period Data**
Rationale: For the practice to receive monthly feedback for the duration of the intervention period (September 2014 – August 2015), regarding self-selected tests of change to improve delivery of obesity prevention and treatment.

Each provider seeking MOC needs a minimum of 10 charts abstracted for 9 out of the 12 months of the collaborative (September 2014-August 2015).
- Time frame: each month of the collaborative
- 10 per provider per month
- Minimum participation by each physician seeking MOC for 9 out of 12 months
- Complete data entry by the last day of each month.

## Initial Data Submission

For the initial data submission due the last day in September 2014 at 10 PM CT, practices may choose to either:

1) Submit the baseline data by September 19, 2014; AND the September monthly project data on September 30, 2014;

**OR**

2) Submit the baseline data on September 19, 2014 AND the start the monthly project data in October with submission by the last day of the month.

## Chart Selection: Post-Intervention

Rationale: for the practice to understand which parts of the obesity prevention and treatment are sustainable.
- Time frame: January 1, 2016-March 29, 2016
- 15 charts per provider
- Complete data entry by May 1, 2016

## Clinical Care, Practice Assessment, Data Abstraction Implementation Manual

***Data Abstraction for: Demographics***

Practice Name: Use the drop down box to select name of practice.

Provider: Use drop down box to select name of provider seeing patient for health supervision visit

Date of Visit: Enter date of health supervision visit (mm/dd/yyyy)

Date of Birth: Month and Year of birth (mm/yyyy)

Gender: Select Male or Female

For XCEL data entry, enter the above data into relevant row and cell

## *Data Abstraction for: Height and Weight*

None

## Data Abstraction: Body Mass Index Calculation and Classification Measurement

BMI Percentage: Enter the BMI percentage documented on the day of the visit in the medical record health supervision visit.

If no BMI percentage documented, select "Not documented."

BMI Classification:
Enter the BMI classification documented at the health supervision visit as one of the following:
BMI <5% and/or underweight
BMI 5 – 84% and/or healthy weight
BMI 85 – 94% and/or overweight
BMI ≥ 95% and/or obese

If no BMI classification noted, select "Not documented."

For XCEL data entry, enter the above data into relevant row and cell

## Data Abstraction: Blood Pressure Measurement Classification

Patients 2 years of age do not routinely have blood pressure screenings at two health supervision visits. If the patient is 2 years of age, select "Patient is 2 years old."

For children and youth 3-17 years of age, enter the systolic and diastolic blood pressure documented in the medical record on the date of the visit.

For children and youth the 3-17 years of age who do not have a systolic and diastolic blood pressure documented in the medical record on the date of this visit, select "not documented."

If the blood pressure was repeated during this visit, abstract only the second measurement.

Blood Pressure %:
For children 3-17 years of age, abstract blood pressure is documented as:
<90% and/or normal
90-95% and/or pre-Hypertension
95-99 +5mmHg and/or Stage I Hypertension
>99+ 5mmHg and/or Stage 2 Hypertension

If blood pressure percentage not documented or blood pressure not assessed as being consistent with "normal" "pre-Hypertension" "Stage 1 Hypertension" or "Stage 2 Hypertension", select "not documented."

For XCEL data entry, enter the above data into relevant row and cell

## Data Abstraction: Preventive Nutrition and Physical Activity Counseling

5210 Handout Provided: If documentation exists that this resource was provided, select the box and - for children and youth with a BMI <85% - STOP abstraction

For practices that choose to use alternative methods to deliver nutrition counseling, select "Nutrition Counseling Provided" if one or more of the following is documented on the date of the visit in the medical record.

- Discussion of current nutrition behaviors
- Parent or patient nutrition screening tool reviewed
- Counseling or referral for nutrition education
- Person received education materials on nutrition
  - 5210 Handout provided
- Anticipatory guidance for nutrition

Select Nutrition counseling "not documented" if one or more the above nutrition counseling items are not documented on the date of the visit in the medical record

## Data Abstraction: Preventive Counseling and Nutrition (continued):

For practices that chose to use alternative methods to deliver, physical activity counseling, select "Physical Activity Counseling provided" if one or more of the following documented in health supervision visit

- Discussion of current physical activity behaviors
- Parent or patient physical activity screening tool reviewed
- Counseling or referral for physical activity
- Person received educational materials on physical activity
- Anticipatory guidance for physical activity

Select Physical Activity counseling, "not documented" if one or more the above nutrition counseling items are not documented on the date of the visit in the medical record.

For XCEL data entry, enter the above data into relevant row and cell

***IF THE CHILD HAS A BMI <85% - DATA ABSTRACTION IS COMPLETE – STOP HERE***

## Data Abstraction: Review of Systems, Family and Social History, Physical Exam, Labs

**None**

## Data Abstraction for Children with BMI 85-94% and ≥ 95%: Readiness to Change Assessed Self-Management Goals Documented

**Readiness for Change Assessed**
***Part 1***
*Select "NO" for Patient and/or parent ready for change if documentation exists that a patient*
-is "not ready for change" or
- is "pre-contemplative" or
- "does not perceive weight as a concern"

***DATA ABSTRACTION COMPLETE – STOP HERE***

Select "BMI 85 – 94% and no risk factors" if the patient is in the weight category but has no risk factors after review of family and medical history, review of the BMI trajectory, diet and activity habits, and appropriate lab tests.

***IF "NO" OR BMI 85 – 94% AND NO RISK FACTORS SELECTED – DATA ABSTRACTION IS COMPLETE – STOP HERE***

***Data Abstraction for Children with BMI 85-94% and ≥ 95%: Readiness to Change Assessed Self- Management Goals Documented***

**Readiness for Change Assessed**

**Part 2**

*Select "YES" for Patient and/or parent ready for change if documentation exists that a patient*
- is "ready for change"; or
- a self- management goal was selected; or
- a confidence ruler was used

**Self –Management Goal Documentation**

Nutrition: select nutrition goal(s) from drop box if one or more parent or patient selected nutritional goal is documented in the medical record for the date of the visit. Select all that apply and enter any other nutrition goals in the text box.

Physical Activity: select physical goal(s) from drop box if one or more parent or patient physical goal is documented in the medical record for the date of the visit. Select all that apply and enter any other physical goals in the text box.

If neither nutrition nor a physical activity goal documented in the medical record, select "not documented.

# Questions

**Lunch and Coding Session to follow.**

**Take a five-minute break to get your lunch and return to your seats.**

ACHIA
Alabama Child Health Improvement Alliance

## Coding for Obesity Prevention and Treatment

*Cason Benton, MD, FAAP*
*UAB Department of Pediatrics*
*ACHIA Director*
*August 23, 2014*

## Commercial Interests Disclosure

E. Cason Benton, MD, FAAP

- Does not intend to discuss commercial products or services.
- Does not intend to discuss non-FDA approved uses of products/providers of services.
- Does not have a relevant financial arrangement or affiliation with any commercial interest related to this activity.



## Important caveats and disclaimers

Coding guidance reflects best practice recommendations from the American Academy of Pediatrics & others
- AAP Coding Fact Sheet for Primary Care Pediatricians
- AAP Practice Management Online (PMO)
- AAP *Coding for Pediatrics* 2014
- AAP Section of Administration & Practice Management (SOAPM)-
- AllKids Provider Update New Obesity Benefits February 2011
- BCBS Preventive Care Services Revised July 2014
- Alabama Medicaid Quality Assurance RCO Measures
- AAP Coding Hotline (aapcodinghotline@aap.org)
- Coding recommendations do not reflect recommendations of ACHIA, Children's of Alabama or UAB
- Know your payers!

## NCQA HEDIS Child Obesity Measure

- **HEDIS 2015… Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**
- The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
- Measurement year: 1/1/20xx – 12/31/20xx
- All outpatient visits included.
- Stratifications: 3–11 years, 12–17 years, total
- Methodologies: administrative data or medical record review.
- Insurance plans (payers) and providers are being measured



## HEDIS Criteria

**Weight Assessment**

- BMI percentile during the measurement year as identified by administrative data or medical record review.
- ICD-9-CM Diagnosis - V85.51 (BMI <5%), V85.52 (5-84%), V85.53 (85-94%), V85.4 >=95%
- Medical Record Review: Documentation must include a note indicating the date on which the BMI percentile was documented and evidence of either of the following.
- BMI percentile, ***or*** BMI percentile plotted on age- growth chart
- For adolescents 16–17 years, documentation of a BMI value expressed as kg/m2 is acceptable.



## HEDIS Criteria

**Counseling for Nutrition**

- Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.
- CPT - 97802-97804, ICD-9-CM Diagnosis - V65.3,HCPCS - S9470, S9452, S9449, G0270-G0271
- Medical Record Review: Documentation must include a note indicating the date and at least one of the following.
- Engagement in discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
- Checklist indicating nutrition was addressed
- Counseling or referral for nutrition education
- Member received educational materials on nutrition
- Anticipatory guidance for nutrition



## HEDIS Criteria

**Counseling for Physical Activity**

- Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.
- ICD-9-CM Diagnosis - V65.41 HCPCS - S9451
- Medical Record Review: Documentation must include a note indicating the date and at least one of the following.
  - Engagement in discussion of current physical activity behaviors (e.g. exercise routine, participation in sports activities, exam for sports participation)
  - Checklist indicating physical activity was addressed
  - Counseling or referral for physical activity
  - Member received educational materials on physical activity
  - Anticipatory guidance for physical activity



## ICD-9 : Body Mass Index codes

- V85.51 Body Mass Index, pediatric, <5th percentile for age
- V85.52 Body Mass Index, pediatric, 5th percentile to <85th percentile for age
- V85.53 Body Mass Index, pediatric, 85th percentile to <95th percentile for age
- V85.54 Body Mass Index, pediatric, ≥95th percentile for age

Use?

Secondary diagnosis for well-child visit

Problem list (paper or electronic record)



## Obesity Codes: ICD-9

- 278.00 Obesity, unspecified
- 278.01 Morbid obesity
- 278.02 Overweight

- Numerous codes for obesity complications and/or co-morbidities
- 783.1 Abnormal weight gain
- See ACHIA Obesity Coding Fact Sheet

## Which obesity code should I use?

- For well-child visit:
  - Use appropriate V code such as V20.2 (ICD-10- Z00.121, z00.129) for primary diagnosis
  - Use V code for BMI%ile for secondary diagnosis (V85.5x)
    - This sends claims message that you measured BMI%ile
    - NCQA HEDIS measure
- For E/M services (at well-child or separate):
  - Use ICD-9 dx code for obesity or co- morbidity to justify E/M service at time of well-child visit or other office visits for obesity screening, counseling, treatment



## Can I code for obesity screening and counseling at well-child visit?

- Basic screening (nutrition, activity, screen time, BMI%ile etc.) and health counseling are part of comprehensive well-child exam
  - Use V20.2 & V85.5x
- If you spend and document significant added time addressing additional health concerns above and beyond basic well-child exam- you can bill for added care with some payers
  - Use appropriate E&M code (99211-99215) and -25 modifier- indicating separate identifiable service performed on same DOS



## Obesity Code Denials

Denials

- Not medically necessary = challenge
  - AAP, AMA, USPSTF recommended care
- Not covered benefit
  - Employer may specifically exclude obesity-related services
  - Patient responsibility
- Disease management carve-out
  - Discuss options with plan



## BCBS Policies
## ***Under Health Care Reform***

- Ages 6 years and older
- One per calendar year
  - 99401with screening for obesity V77.8



## ALL Kids Obesity Benefits

- For Patients with an ICD-9 code V85.54
  - 4 annual office visits
  - 2 annual nutritional counseling visits *(Physicians CPT codes 97802 and 97803)* with an eligible provider



## Medicaid: RCOs

- Quality Assurance Measures
  - BMI %
  - Nutrition Counseling
  - Physical Activity Counseling

## Additional ICD9 Codes to Consider When Applicable

- 783.1 Abnormal Weight gain
- 701.2 Acanthosis
- V18.0 Family history of DM
- 401.9 Hypertension
- V17.49 Family history of heart disease
- 277.7 Insulin Resistance/Dysmetabolic Syndrome



## Other ICD9 codes to Consider When Appropriate

- 278.0 Obesity
- 278.01 Morbid Obesity
- 278.02 Overweight
- 272.0 Pure hypercholesterolemia
- 272.1 Pure hypertriglyceridemia
- 272.2 Mixed hyperlipidemia
- 272.4 Other hyperlipidemia
- 277.7 Insulin Resistance



## Other ICD9 codes to Consider When Appropriate

- 786.09 Respiratory Distress, not acute
- 429.2 Cardiomegaly
- 780.71 Chronic Fatigue syndrome and development
- 786.05 Shortness of Breath
- 327.23 OSA
- 611.11 Hypertrophy of breast
- 783.9 Other sxns concerning metablism
- V65.41 Exercise Counseling



## Other Codes to Consider

- Dyslipidemia Screening
  - BCBS- *under healthcare reform*
  - Code 80061 with v77.91
    - Ages 2-10 years: once every 2 calendar years
    - Ages 11-17 years: one each calendar year
    - Ages 18-21 years: once in age range



## The Coding Pearls
## The Preventive Medicine Code

If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/ abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code99201-99215 should also be reported.

Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported. "



## The Coding Pearls
## The Modifier -25

- The modifier *ALWAYS* goes on the E/M code
- When a Prev. Medicine code and an E/M office visit for a problem are billed together, ALWAYS put the -25 on the non-prev. E/M code
- Never attach the -25 to a non-E/M code

## The Coding Pearls
## The Modifier -25

- When a separate problem is evaluated and reported with a NEW patient preventive medicine service-
- D Use the NEW OV/Outpatient codes 99201-99205



## The Coding Pearls
## The Modifier -25
## Sick + Well

**What is Significant?**

- **A separate visit would have been required to take care of the problem**
- **A problem requires an RX to treat**



## The Coding Pearls
## The Modifier -25
## Sick + Well

**What is Separate?**

- Additional documentation is needed
- Separate documentation helps you select the correct E/M code level
  - Addit. Hx, pe, mdm
- Separate documentation also helps you with an audit-keeps auditors happier- just like legible writing – can be a challenge with EHRs



## What degree of documentation is recommended?

- Documentation should support added service (Hx, PE, MDM, counseling, time)
  - Could it billed as "stand alone" visit?
- One note vs two notes?
  - Document so added care is clear



## Office or Other Outpatient Services- Established Patient

Document either **2 or 3 key components** (history, examination, & medical decision making) OR time spent counseling the patient



## Coding Based on Time

- An explicit factor to assist in selecting the most appropriate level of E/M services
- ***When counseling and/or coordination of care are more than 50% of the face to face encounter, time is the key controlling factor.***
- Documentation of time in the medical record is a must in this situation

## Counseling

- **Discussion with a patient and/or family concerning**
  - Diagnostic studies or results
  - Prognosis
  - Risks and benefits of management options
  - Importance of compliance
  - Patient and family education



## Typical Times for Outpatient Services

- Select time closet to typical time

| | |
|---|---|
| 99201- 10 min | 99211- 5 |
| 99202- 20 min | 99212- 10 |
| 99203- 30 min | 99213- 15 |
| 99204- 45 min | 99214- 25 |
| 99205- 60 min | 99215- 40 |



## What About Co-Pays?

- Health Care Reform: no co-pays for preventive care services (including well-child exams)
- Several plans now requiring patient co- pays if E&M service (-25 modifier) billed on same DOS
  - For obesity or any other significant concern
- Families confused/angry; office staff under fire



## Strategies

- Share office policy in advance?
- Handouts or signs in practice waiting area, website?
- What should be included in message?



## A Suggestion for Office Message: "Understanding My Bill and Co-Pays"

- No co-pays are required for most preventive care services (or care provided to Medicaid-enrolled children.)
- Many times children have extra concerns about their health or behavior that require extra time and not part of a routine preventive care visit.
- For the convenience of children and families, and when schedules permit, we try to address these added problems as part of your child' s "check up" office visit.
- In this situation, as per guidelines developed by the AMA and American Academy of Pediatrics, we will bill for the added office visit time.
- Several insurance companies are now asking that we collect a co-pay from families when we address these extra problems in addition to the check-up visit.
- If more convenient, we can also schedule a separate appointment to address these additional health concerns.
- Our goal is to deliver the very best care to your child and family- comprehensive, convenient and fairly priced.
- If you ever have any questions about your bill, please feel free to speak with our billing manager (xxx). Your pediatrician is always available to answer questions about your child' s care, health, diagnosis and bill



## Questions?

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**Team Meeting 2:**
**Developing a PDSA Around Reliable Workflow**

*Daniel Preud'Homme, MD, CNS, FAAP*
*Professor of Pediatrics*
*University of South Alabama*
*August 23, 2014*

## Commercial Interests Disclosure

Daniel L. Preud'Homme, MD, CNS, FACN, FAAP

- Does not intend to discuss commercial products or services.
- Does not intend to discuss non-FDA approved uses of products/providers of services.
- Does not have a relevant financial arrangement or affiliation with any commercial interest related to this activity.

## Objectives

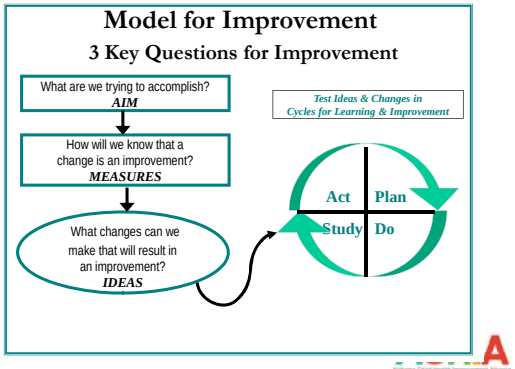
1. Describe the Performance Improvement (PI) Model
2. Describe the Plan-Do-Study-Act cycle.
3. Review some PI tools

## What is Performance Improvement?

- The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals

## What is a Performance Improvement Model?

- *A PI Model is a process used to improve a process or to carry out change.*
- *The most common PI model used in health care is the 4 stage problem solving model called PDSA, rapid cycle improvement model.*



## Plan-Do-Study-Act

| Team | Aim statement | Examine present approach | Potential solutions | Improvement theory |
|---|---|---|---|---|
| Assemble the team<br>• Invested people<br>• Specific roles | *"Workable workflow in the clinic"* | S-trength<br>W-eaknesses<br>O-pportunities (external +)<br>T-hreats (external --) | Review best practices<br>Brainstorm ideas<br>Refine AIM | Start with the hypothesis<br>How do we TEST? |
| • Timeline<br>• Meeting time | Is this an improvement? | *Flow charts* | | Collect Data Document. |
| | How to make this an improvement | Cause and effect Fishbone | | |

## Meeting Skills

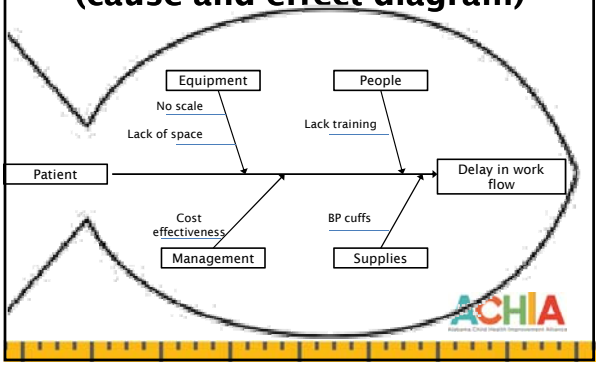

## 7-Step Meeting Process/Agenda

1. Clarify aims: what we will get done
2. Review roles: leader, recorder, timekeeper, facilitator
3. Review agenda and determine time for each item
4. Work through agenda items
5. Review meeting record: review written record (flipchart, computer, whiteboard) make changes/additions, decide what to keep for meeting record
6. Plan next actions & next agenda: who will do what off line & aims for next meeting
7. Evaluate the meeting: went well, could improve

## Plan-Do-Study-Act

| Team | Aim statement | Examine present approach | Potential solutions | Improvement theory |
|---|---|---|---|---|
| Assemble the team<br>• Invested people<br>• Specific roles | *"Workable workflow in the clinic"* | S-trength<br>W-eaknesses<br>O-pportunities (external +)<br>T-hreats (external --) | Review best practices<br>Brainstorm ideas<br>Refine AIM | Start with the hypothesis<br>How do we TEST? |
| • Timeline<br>• Meeting time | Is this an improvement? | *Flow charts* | | Collect Data Document. |
| | How to make this an improvement | Cause and effect Fishbone | | |

## Fishbone (cause and effect diagram)




## Plan-Do-Study-Act

| Team | Aim statement | Examine present approach | Potential solutions | Improvement theory |
|---|---|---|---|---|
| Assemble the team<br>• Invested people<br>• Specific roles | *"Workable workflow in the clinic"* | S-trength<br>W-eaknesses<br>O-pportunities (external +)<br>T-hreats (external --) | Review best practices<br>Brainstorm ideas<br>Refine AIM | Start with the hypothesis<br>How do we TEST? |
| • Timeline<br>• Meeting time | Is this an improvement? | *Flow charts* | | Collect Data Document. |
| | How to make this an improvement | Cause and effect Fishbone | | |

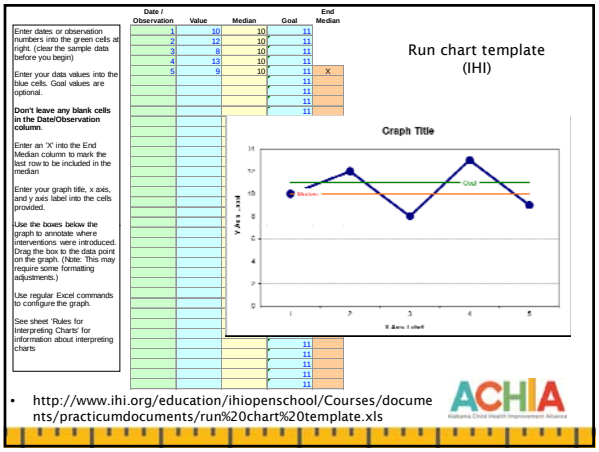
## Plan-Do-Study-Act

**Start carrying out your plan**

| Encounter form | TEST the form | Collect the data | Document the process | Document unexpected issues |
|---|---|---|---|---|
| ➢ Educate staff/team<br>➢ Construct the form<br>➢ Establish roles | when | How many? | Display the process in a staff friendly area/work area. | Fishbone cause and effect |

## Some tools

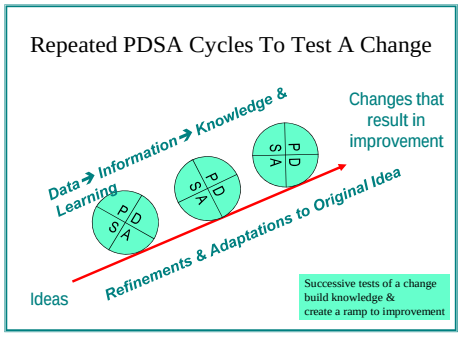
- Check sheet
- Flowcharts
- Run charts
  - Place the run chart in an area available to most so to motivate




- http://www.ihi.org/education/ihiopenschool/Courses/documents/practicumdocuments/run%20chart%20template.xls

## Encounter Forms

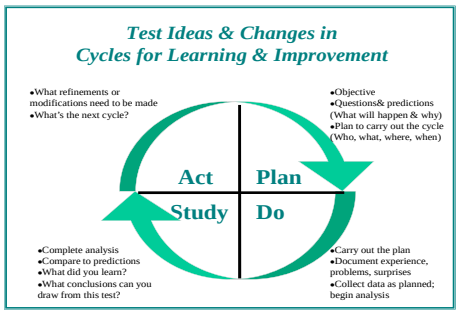
- Plan specifics of use of the Healthy Active Living clinical encounter form
  - How are patients identified
  - Who places the form on the chart or creates the form in the electronic health record
  - Who completes the form
  - Where is form stored for data entry
  - Who enters the data and when




## Time for Action

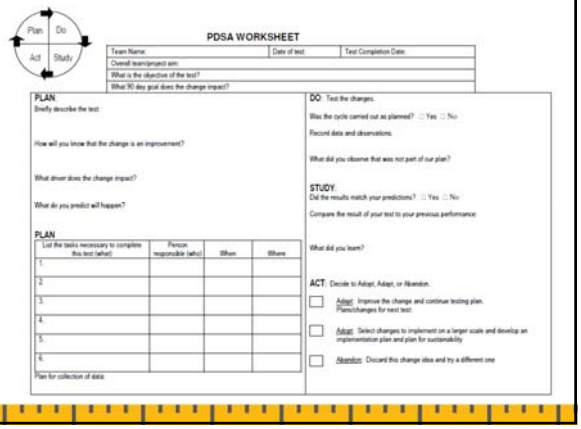
- Plan your first PDSA **cycle** for implementation of encounter form into daily workflow
- Use your current state and high reliability flowchart to guide your tests of change
- Keep it simple
- Make it very specific

## Plan-Do-Study-Act




## Let us look at the work sheet

- Please start to fill in the
  - Name
  - Overall AIM
  - Objectives of the Test (of change)
  - What 90 days Goal does the change impact?




## Team Time Assignment #2

**20 minutes**

- Practice Teams will draft their 1st PDSA cycle to create the use of the HAL Encounter form into their practice setting
- PDSA sheet is in your packets

## Team Reports

**10 minute report out of Practice Teams PDSAs**

## Break

**Jazzercise**
**Let's Get Up and Move with Dr. Jasmine Pagan!**

**15 minutes**

Alabama Child Health Improvement Alliance

## Introduction to Motivational Interviewing

*Bonnie Spear, PhD, RDN, LD,*
*UAB Pediatrics*
*August 23, 2014*

## Commercial Interests Disclosure

Bonnie A. Spear, PhD, RDN, LD

- Does not intend to discuss commercial products or services.
- Does not intend to discuss non-FDA approved uses of products/providers of services.
- Does not have a relevant financial arrangement or affiliation with any commercial interest related to this activity.

## Essence of MI

Comfort the afflicted
and
Afflict the comfortable

Empathy vs. Discrepancy
Barriers Allowed-Benefits Encouraged
Acknowledge Dread of Change

## Three Phases of Motivational Interviewing

| | Objectives | Techniques Used |
|---|---|---|
| Following: (what, why, Why not) | Obtain History<br>Build Rapport | Open-Ended Questions<br>Reflective Listening<br>Agenda Setting;<br>Asking Permission |
| Guiding: (IF) | Elicit Change Talk | Pros and Cons;<br>Interest/Confidence<br>Elicit-Provide-Elicit;<br>Summarizing |
| Directing: (when/how) | Patient Identify Goal(s)<br>Patient/client chooses Action Plan | Build a Menu<br>Discuss Next Steps and Monitoring Plan |

## Techniques to assist change

- **O**pen-ended questions
- **A**ffirmations
- **R**eflections
- **S**ummaries

## Poll

Several Poll Questions

## Is it 1-Open or 2-Closed?

- What do you like about exercise?

## Is it 1-Open or 2-Closed?

- Have you thought about walking as a simple form of exercise?

## Is it 1-Open or 2-Closed?

- What things have you tried as a family to help with your families health and weight?

## Is it 1-Open or 2-Closed?

- What do you want to do about your smoking: quit, cut down or stay the same?

## Is it 1-Open or 2-Closed?

- Can you try limiting fruit drink to 4 times this week?

## Phrases for Open-Ended Questions

- Tell me why…
- Tell me about…
- Tell me how you have…
- I'm interesting in hearing why you…
- I'd like to hear your thoughts about…
- Explain what you might do…
- Give me some examples of…

## Common Closed Questions

- Do you…
- Is that a concern…
- Is there any way…
- Are there any…
- Is there anything you can….
- Have you..
- Can you tell me…
- Would you…

## Techniques to assist change

- **Affirmations**
  - Need to be congruent and sincere
  - Increase belief in ability to change
  - Give information about how clients are already working toward change
  - Cause the habits you praise to increase
  - Helps with rapport and increases empathy

## Techniques to assist change

- **Reflective listening**
  - Statement not a question
  - Shows you are listening
  - Demonstrates understanding and acceptance
  - Ends with a down turn
  - Hypothesis testing
    - "If I understand you correctly, it sounds like…"
  - Encourages personal exploration
  - Keeps the client thinking and talking

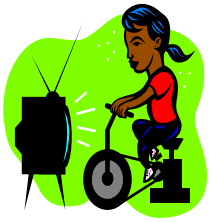
## Reflective Listening Phrases

- It sounds like you…
- It's difficult/easy for you to…
- You realize that…
- You're having trouble/success with…
- You understand that…
- You feel that…
- You do/don't see the need to …
- Let me see if I understand you…

## Health Behavior Change: The Feeling Vocabulary

- Trapped
- Torn
- Hopeless
- Powerless
- Alone
- Overwhelmed
- Drained

Amplified double sided



Action Reflections

## Summarizing and Closing the Deal

- "If it's ok, I would like to go over what we have discussed today."
- Summarize pros and cons of change.
- **Closure** – "What do you think might be a first step?"
- **If ambivalent**: "Would it be okay if I shared some strategies that have worked for other families?"
- **If not ready to change**: "It seems that you are not ready to make a change at this time …."

## Closing the Deal

What do you want to do about your…. (smoking, diet, exercise)?

It sounds like you have some pretty good reasons to ..what do you make of all this?

It sounds like you want to do something about …….what's your next step?

Tell me how you might go about that?

Where does that leave us? OR Where would you like to go from here?

Which of these do you think might work best for you?

## Closing the Deal

Here are some things that have worked for other people

1) Amazing Strategy 1
2) Amazing Strategy 2
3) Amazing Strategy 3


Which of these do you think might work best for you?

Which of these might you be willing to try?

Where does that leave us? OR Where would you like to go from here?

## Roll with Resistance

- Avoid problem-solving
  - *"Yes, but…."*
    - Sign of ambivalence
- Develop discrepancies
  - Between client's current behavior and goals
- Are you wrestling or dancing?
- **Resistance is a sign for the counselor to change the approach!**

## Rolling with Resistance

**Complete session increasing exercise**

Alabama Child Health Improvement Alliance

# Scoring a Segment on Motivational Interviewing and Hands-on Training

*Bonnie Spear, PhD, RDN, LD*
*UAB Pediatrics,*
*August 23, 2014*

## Commercial Interests Disclosure

Bonnie A. Spear, PhD, RDN, LD

- Does not intend to discuss any commercial products or services
- Does not intend to discuss any non-FDA approved uses of products/providers of service
- Does not have a relevant financial arrangement or affiliation with any commercial interest related to this activity.

## Coding Form

| | | |
|---|---|---|
| **Giving Information** | | |
| ***MI*** Adherent | **Asking permission, affirm, emphasize control, support.** | |
| ***MI*** Non-adherent | **Advise, confront, direct.** | |
| **Questions** | **Closed Question** | |
| | **Open Question** | |
| **Reflections** | | |
| | **TOTAL REFLECTIONS:** | |

Barlow 2nd tape

## Questions

- What did you notice about the session?
- What worked?
- What happened when the resistance built up?
- What would you have done differently?
- What about the comment about lemonade?

Rx for Healthy Active Living

Name _____ Date _____

**Ideas for Living a Healthy Active Life**

5 2 1 0
- Eat at least 5 fruits and vegetables every day.
- Limit non-homework screen time (TV, video games, computer) to 2 hours or less per day.
- Get 1 hour or more of physical activity every day.
- Drink fewer sugar-sweetened drinks. Try water and low-fat milk instead.

**My Goals (choose one you would like to work on first)**

- ☐ Eat_____fruits and vegetables each day.
- ☐ Get_____minutes of physical activity each day.
- ☐ Reduce screen time to_____minutes per day.
- ☐ Reduce number of sugared drinks to_____per day.

_____
Child or Parent/Teen

_____
Doctor Signature

From Your Doctor

## Implementing in your practice

- How will MI work in your practice?
- What do you see as the benefits?
- What do you see as the barriers?

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## What Needs to Happen in Action Period I

Children's of Alabama

UAB MEDICINE PEDIATRICS

*Cason Benton, MD, FAAP*
*August 23, 2014*

## Commercial Interests Disclosure

E. Cason Benton, MD, FAAP:

- Does not intend to discuss any commercial products or services
- Does not intend to discuss any non-FDA approved uses of products/providers of service
- No significant financial relationship

ACHIA

## What Needs to Happen in Action Period 1?

**Strengthen QI methods and approaches**

- Review QI Materials
- Attend monthly practice conference calls and webinars
- Utilize resources/tools available (Resource Workspace)
  - Steal shamelessly and often

ACHIA

## What Needs to Happen in Action Period 1?

**Develop the capacity of your QI Team:**

- Form your team and identify the target population
- Refine your Aim Statement and share with all practice members
- Team understands the Practice Key Driver Diagram
  - Display in the office – common areas
- Engage all members in your practice
  - This may take some time, but can still get MOC for MDs, even if you start "a little" late
- Identify what/how/when to communicate with others in your practice to bring them along.

ACHIA

## What Needs to Happen in Action Period 1?

- **Develop/Refine the "systems approach" to Obesity Prevention and Treatment Care**:
  - Refine mapping your office flow to fully understand the changes you are testing and implementing
  - Continue to modify the HAL Encounter Form to meet the needs of your practice
- **Submit Monthly HAL data**

ACHIA

## Practice Core QI Team Huddles/Meetings

- Identify personnel for key roles (practice core team members,, lead for data entry, etc.)
- Set up standing time at least twice a month for 30 min. to 1 hour for the core QI team to review data and develop areas of focus over a defined period of time (PDSA testing)
- Identify a facilitator, time keeper and recorder for each meeting
- Use P-D-S-A worksheets to document your plan, what you learned and next cycle
- Conduct brief huddles as much as needed to review P-D-S-A cycle planning and implementation
- Begin to set 30, 60, and 90 day goals (to be discussed further on monthly practice calls)

## Using Data to Measure Your Performance

- Abstract and upload baseline data
- Abstract and upload monthly action period data
- Determine staff work flow to abstract monthly data
- Review and use monthly performance data monthly to identify change areas

## Monthly Data Collection & Reporting Cycle

- Collect and enter baseline data
- Enter at least 10 patient encounters per month per physician by the last day of each month at 10 PM CT
- Collect and Submit monthly data for 9 out of the 12 months of the collaborative

## Baseline Data

- Baseline data collection:
  - 15 charts per provider for patients seen February 1- July 31, 2014.
  - Entered into the HAL Database by September 19, 2014 at 10 PM CT.

## Project Data Collection

- Project Data collection – Monthly Action Periods (for 9 out of the 12 months beginning September 1, 2014 and ending August 31, 2015):
- 1st data collection period: September 1, 2014 – September 30, 2014. Entered by September 30, 2014 by 10 PM.
- Each month thereafter: 10 charts per provider self selected each month entered into the HAL Database by the last day of the month at 10 PM

## Initial Data Submission

For the initial data submission due the last day in September 2014 at 10 PM CT, practices may choose to either:

1) Submit the baseline data by September 19, 2014; AND the September monthly project data on September 30, 2014;

**OR**

2) Submit the baseline data on September 19, 2014 AND the start the monthly project data in October with submission by the last day of the month.

## Communication to staff & clinicians in your practice

- Set up a data display area for clinicians and staff to post HAL- QI Monthly data and project information
- Request to include a monthly update on HAL-QI at practice staff meetings
- Review key aspects of project, including measures and aims with partners/senior leaders

## Save the Dates: Monthly Webinars and future Learning Sessions

**Monthly Practice Webinars**: third Wednesday of each month at 12 – 1 PM CST (LS2 and LS4 will take the place of the monthly practice call in December 2014 and August 2015) .

The HAL-QI practices will access ReadyTalk for the monthly practice webinar.

**Next Monthly Practice Call**: Wednesday, September 17, 2014 at 12 PM CT

## Future Learning Sessions

**Mark your calendar for the future Learning Session Dates**:

- LS2 (Webinar): Wednesday, December 17, 2014 (12 – 1 PM CST)
- LS3: (Face-to-Face): Saturday, April 18, 2015, the Bradley Center in Birmingham
- LS4: (Webinar): Wednesday, August 19, 2015 (12-1 PM CST)

## Questions?

## Training Evaluations

**Take 5 minutes to complete the training Survey and CME evaluation (green sheet) before you leave today!**

## CME Information

Children's of Alabama designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of Children's of Alabama and the Alabama Child Health Improvement Alliance. Children's of Alabama is accredited by the Medical Association of the State of Alabama to provide continuing medical education for physicians.